STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED			
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\$ 000	Initial Comments			S 000				
	This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 06/08/10 and finalized on 06/08/10, in accordance with Nevada Administrative Code, Chapter 449, Hospitals.				2	8/12/10		
					b.) All patients, hospital and medical staff, and visitors present within the Siena campus during an emergency drill		Ą	
	Complaint #NV000 deficiencies cited. (See Tags S0089,S	25533 was substanti 60298)	1		(including individual with weapon) are identified as having the potential to be affected by the identified deficient practice.			
	The POC must related and prevent such of intended completion	Plan of Correction (POC) must be submitted. POC must relate to the care of all patients prevent such occurrences in the future. The ended completion dates and the mechanism(s) ablished to assure ongoing compliance must included.			practice.  c.) Immediately upon completion of the emergency drill, a debriefing was convened to address identified problematic issues relating to the implementation of the drill. Participants in the debriefing included hospital leadership (including Chief Operating Officer, Emergency & Security Management, and ICU leadership) and front-line clinical staff			
	on-going compliand requirements.		1	7-13-18	involved in the drill. As a result of	of the		
	by the Health Divisi prohibiting any crim actions or other cla	onclusions of any inv on shall not be cons inal or civil investiga ims for relief that ma ty under applicable t	trued as tions, y be		debriefing (and subsequent inverse a temporary moratorium was planemergency drills until EM communications are revision, emergency as a procedure development and and comprehensive staff education be implemented.	aced on nittee drill policy appropriate		
	The following defici	encies were identifie	ed.		consideration and investigation hospital leadership, SRDH staff	by senior f involved		
S 089 SS=H	NAC 449.316 Emer		1	S 089	in the planning and implementa drill were counseled and discip	ition of the		
	comprehensive pla which: (a) Addresses inter both local and wide	ent standards for dis	paredness ergencies,		indicated:  • Employee #1 was placed on administrative leave and remove their leadership role as Emerge Management (EM) Committee	ved from ency Chair.		
	_	plan of correction must be	returned with	n 10 days at	ter receipt of this statement of deficiencie	ECEIV	<del></del>	

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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

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Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS2969HOS** 06/08/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3001 ST ROSE PARKWAY SAINT ROSE DOMINICAN HOSPITAL - SIENA ( HENDERSON, NV 89052 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 089 S 089, Continued: S 089 Continued From page 1 This Regulation is not met as evidenced by: Employee #2 was placed on Based on observation, interview and document administrative leave and removed from review the facility failed to carry out a their leadership role as Safety Officer and comprehensive plan for emergency preparedness Environment of Care (EOC) Committee by failing to have a policy or procedure in place to Chair. plan, coordinate and conduct emergency and · Employee #3 was terminated from armed terrorist hostage drills at the facility and to employment. ensure the safety of the nursing units and provide · Other members of EOC and EM for uninterrupted patient care and supervision. committee were identified and counseled. The leadership positions identified above Findings include: were filled immediately on an interim basis On 06/08/10 at 10:20 AM an interview was - The Chief Operating officer will be conducted with Employee #4. (Chief Operating fulfilling the EOC and EM Committee Officer) Employee #4 reported an armed hostage Chair responsibilities while our parent drill was planned and implemented by Employee corporation, Catholic Healthcare West #1 (Director Chair of Emergency Management) (CHW) has provided Siena with Employee #2 (Chair of Environment of Care individuals to fulfill the Director of Security Committee) and Employee #3. (Director of responsibilities. Security) The armed terrorist role player was an A policy addressing emergency drill off duty Metro Police Officer who participated in planning, notification, and implementation the drill with a real unloaded firearm. The drill was was developed and approved by senior conducted on 05/24/10 at 10:00 AM on the ICU leadership. (See Exhibit A - Emergency unit. (Intensive care unit) Event Drill Codes Policy). The official policy approval process has been initiated Employee #4 acknowledged Employee #1, #2 and tentative official finalization and and #3 failed to advise the administrators of the approval is set for July 12, 2010. A hospital, ICU managers, ICU supervisors or ICU preliminary draft version of the policy and staff members about the drill prior to new process (as well as revised implementation of the drill. None of the employees developed or submitted a written responsibilities and expectations) was scenario of the drill to administrators for approval communicated on a one-to-one basis to all prior to implementation. The Employee #4 individuals involved in drill planning reported all drills conducted at the facility were to process on June 4th, 2010 by our Chief be announced as an overhead page prior to the Operating Officer. Education concerning drills implementation and nurse managers were the new policy is on the agenda for the to be notified ahead of time prior to the drill being next Siena Management meeting on July conducted. Employee #4 acknowledged the 27, 2010 and the Siena EOC Committee armed terrorist drill was not announced as a drill on July 22nd, 2010. and staff thought there was a real armed hostage

STATEMEN	Bureau of Health Care Quality and Compliance  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NVS2969HOS		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/08/2010		
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	Manager was not not drill prior to the drill #4 reported on 05% code grey (assault aggressor) on the loverhead speaker.	the ICU unit. The ICU officed of the armed I is implementation. Er 24/10 at 10:00 AM short threat by an unarr CU unit being annou At 10:10 AM she he	nostage nployee le heard a ned nced on ard a		Education will include all staff expectations and responsibilities during the planning and implementation of an emergency drift. All Siena staff will receive new policy education within 30 days of its approval (July 12th). This education will		
	with an armed agg Employee #4 report and code silver we situation because r	silver (assault, threat or hostage situation in armed aggressor) on the ICU unit. oyee #4 reported she thought the code grey ode silver were a real armed hostage ion because no drill was announced after codes were announced.			be implemented by various methods: electronic communication (staff bulletins and newsletters), staff meetings, in- services, read and signs, and one-to-one personal communication.  d.) Siena will monitor its corrective actions		
	Employee #4 reported she called the ICU unit and spoke with an employee who advised her they could not talk with her because something was happening. Employee #4 reported she responded to the ICU unit and made contact with Employee #2 who advised her that the code silver was a drill. Employee #4 reported she informed Employee #2 that the hospital staff did not know the code silver was a drill. Employee #4 reported once she was convinced the ICU staff was unaware the code silver was a drill she confronted Employee #1. Employee #1 then terminated the drill after she realized the ICU staff was in panic mode. Employee #4 reported Employee #1 and Employee #2 were placed on suspension following the incident. Employee #3 was terminated from employment.			>	d.) Siena will monitor its corrective actions with written evaluations of every emergency event and drill performed in the facility. The evaluation will be conducted by EM committee members in collaboration with staff, patients, and visitors involved in the event. The evaluation will follow the process defined in the hospital's Emergency Operations Plan (EOP) (See Exhibit B – Emergency Operations Plan (EOP), Page 14; Exhibit C – Exercise Action Plan for Improvement Template; Exhibit D – Sample Event Evaluation Guide (EEG)) and the newly approved Emergency Event Drill Codes Policy (See Exhibit A). The evaluation(s) will be communicated to hospital leadership for appropriate action and approval.		
	nurses, two Physicians, a Respiratory Therapist, Director of the ICU, ICU Charge Nurse and a House Supervisor were detained in a break room on the ICU unit for approximately 15 to 20 minutes during the drill and prevented from participating in patient care duties until the drill was terminated. Employee #4 confirmed prior to				e.) Responsible Party: Chief Operating Officer, St. Ro Dominican Hospitals- Siena Ca f.) Date of Complete Correction 12, 2010	mpus. ECEIV	ED
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Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A BUILDING B. WING **NVS2969HOS** 06/08/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3001 ST ROSE PARKWAY SAINT ROSE DOMINICAN HOSPITAL - SIENA ( HENDERSON, NV 89052 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY S 089 Continued From page 3 S 089 the implementation of the armed hostage drill conducted on the ICU unit, the facility did not have a written policy or procedure that outlined the process for conducting emergency safety drills to ensure the safety of the staff and environment and prevent the interruption of patient care. Employee #4 acknowledged several of the ICU staff and nurses were emotionally traumatized by the armed hostage drill. On 06/08/10 at 11:30 AM an interview was conducted with the Director of the ICU unit. (Employee #5) Employee #5 reported she was never informed by the hospital administration that an armed terrorist drill was going to be conducted in the ICU unit prior to the drills implementation. Employee #5 confirmed none of the ICU staff were informed of the armed terrorist drill prior to the drills implementation. Employee #5 reported on 05/24/10 between 9:30 AM and 10:00 AM she was conducting multidisciplinary rounds with staff members prior to visiting hours on the ICU unit. Employee #5 reported she was informed by a staff member that an agitated male subject on the ICU unit wanted to speak with someone from administration. Employee #5 reported Employee #6 went to talk with the subject who refused to speak with her and demanded to speak with someone from administration. A code grey (assault or threat by an unarmed aggressor) was called by Employee #12. Employee #5 reported she responded to the male subjects location with Employee #6 and made contact with him and asked the subject to come to her office to talk. Employee #5 reported at that time the subject brandished a gun and directed her, Employee #6, Employee #7 and Employee #8 at gunpoint to a break room at the end of the hall. There were two security quards sitting at a If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of defic

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AND FEAR OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2969HOS		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPLI	(X3) DATE SURVEY COMPLETED 06/08/2010	
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	the subject to put the break room the get up against a wa feared for her life at #6 was visibly upse reported two other and Employee #10 patient care and we directed to come insgunman and detains brought into the bre Employee #5 report lapsed until the gun detained in the breaduty Metro Police O drill. All the employee	ak room who were di aleir radios down. Onc subject directed eve all. Employee #5 repond could see that Em t and crying. Employe staff nurses, Employe who had been provide the break room and detained. Two physicians wak room and detained approximately 5 roman informed everyook room that he was a fficer and the incider ses inside the break room that he was a fficer and the drill and the ses two staff nurses prevented from providering airway suction of the drill and the prevented from providing airway suction of the drill and the drill and the drill and the drill and the grevented from providing airway suction of the drill and the drill and the drill and the drill and the grevented from providing airway suction of the drill and the drill	ce inside ryone to red she ployee ee #5 ee # 9 ling were by the vere also d. minutes one an off et was a ran com until mistration by armed uld have ployee census the es and riding luration es #7 ing to a #7 ing	S 089				

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Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING B. WING NVS2969HOS 06/08/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3001 ST ROSE PARKWAY SAINT ROSE DOMINICAN HOSPITAL - SIENA ( HENDERSON, NV 89052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 089 Continued From page 6 S 089 because she was going to be detained for a while. Employee #9 reported she felt she was involved in a real armed hostage situation and feared for her life. She saw other employees inside the break room were crying and visibly upset. Employee #9 reported two to three minutes elapsed before the subject identified himself as an off duty Metro Police Officer and announced the incident was a drill. Employee #9 reported all the employees inside the break room were detained for an additional ten minutes prior to the termination of the drill. Employee #9 reported she felt patient care had been compromised on the ICU unit because she and Employee #10 were prevented from providing patient care and supervision to a patient experiencing episodes of hypotension and bradycardia and were prevented from providing care to their assigned patients during the duration of the drill. Employee # 9 reported no nurses were assigned to monitor her patients during the time she had been detained in the drill. Employee #9 reported Physician #1 and Physician #2 who had been detained in the break room for ten minutes during the drill complained that they were kept from conducting rounds on sick patients they needed to see. Employee #9 reported none of the ICU staff was notified of the armed hostage drill prior to implementation of the drill and when the code grey and code silver were announced facility staff thought there was a real armed hostage situation occurring on the ICU unit. On 06/08/10 at 1:30 PM an interview was conducted with Employee #11. Employee #11 reported she was walking to the ICU break room with a breakfast tray when she saw a male subject ten to fifteen feet away from her pointing a gun at her. Employee #11 placed the tray down

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Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS2969HOS 06/08/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3001 ST ROSE PARKWAY SAINT ROSE DOMINICAN HOSPITAL - SIENA ( HENDERSON, NV 89052 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S 089 Continued From page 7 S 089 and dialed the hospital operator and called a code silver. (assault, threat or hostage situation with an armed aggressor) Employee #11 reported she feared for her life and ran down the hall and closed the double doors to the ICU unit. Employee #11 reported she was then told by Employee #1 that the incident was a drill. Employee #11 reported the facility failed to announce the armed hostage incident as a drill and she and the other employees on the ICU unit thought there was a real armed hostage situation occurring on the ICU unit. Employee #11 reported patient care had been compromised on the ICU unit because the ICU unit had a full census of 26 patients at the time of the drill and the ICU Director, Charge Nurse, two staff nurses and two physicians that had been detained in the break room for approximately ten to fifteen minutes during the drill and were prevented from performing patient care duties. Employee #11 reported many of the nurses on the ICU unit were emotionally traumatized by the armed hostage drili. Severity: 3 Scope: 2 Complaint # 25533 S 298 NAC 449.361 S 298 NAC 449.361 Nursing Service S 298 SS=H 9. A hospital shall ensure that its patients receive 8/12/10 a.) N/A proper treatment and care provided by its nursing services in accordance with nationally recognized b.) All patients and hospital/medical staff standards of practice and physicians' orders. present within the Siena campus during an emergency event or drill (including individual with weapon) are identified as This Regulation is not met as evidenced by: having the potential to be affected by the Based on interview and document review the identified deficient practice. facility failed to ensure patients on the ICU unit

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Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CHA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING **NVS2969HOS** 06/08/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3001 ST ROSE PARKWAY SAINT ROSE DOMINICAN HOSPITAL - SIENA ( HENDERSON, NV 89052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S 298 Continued From page 8 S 298 S 298, Continued: received proper care and supervision during an c.) As part of Siena's Emergency unannounced armed hostage terrorist emergency Operation Plan (EOP), contingencies for drill conducted at the facility. patient care, treatment, and services are addressed. During the drill, no delay in care, treatment and services was Findings include: identified through our event reporting and tracking system. Throughout the On 06/08/10 at 10:20 AM an interview was emergency drill, all ICU patients received conducted with Employee #4. (Chief Operating Officer) Employee #4 reported an armed hostage continuous cardiac and oxygenation drill was planned and implemented by Employee monitoring. We do recognize the need for #1 (Director Chair of Emergency Management) improved communication, planning, and Employee #2 (Chair of Environment of Care implementation of emergency drills. We Committee) and Employee #3. (Director of included these aspects in the Security) The armed terrorist role player was an development of the new Emergency Event off duty Metro Police Officer who participated in Codes Drill Policy (See Exhibit A). The the drill with a real unloaded firearm. The drill was policy addresses the requirement for conducted on 05/24/10 at 10:00 AM on the ICU senior leadership, as well as clinical unit. (Intensive care unit) leadership to collaborate in the implementation of all emergency drills to Employee #4 acknowledged Employees #1, #2 ensure seamless provision of care. and #3 failed to advise the administrators of the treatment, and services. Education hospital, ICU managers, ICU supervisors or ICU concerning the new policy will be staff members about the drill prior to implemented within 30 days after official implementation of the drill. None of the approval scheduled for July 12, 2010. This employees developed or submitted a written education will be implemented by various scenario of the drill to administrators for approval methods: electronic communication (staff prior to implementation. Employee #4 reported all bulletins and newsletters), staff meetings, drills conducted at the facility were to be announced as an overhead page prior to the drills in-services, read and signs, and one-toimplementation and nurse managers were to be one personal communication. notified ahead of time prior to the drill being conducted. Employee #4 acknowledged the d.) Siena will monitor its corrective actions armed terrorist drill was not announced as a drill with written evaluations of every and staff thought there was a real armed hostage emergency event and drill performed in crisis occurring on the ICU unit. The ICU Nurse the facility (See exhibit C - Evaluation and Manager was not notified of the armed hostage Corrective Action Plan Template) The drill prior to the drills implementation. Employee evaluation will be conducted by EM #4 reported on 05/24/10 at 10:00 AM she heard a committee members in collaboration with code grey (assault or threat by an unarmed

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S 298	Continued From pa	Continued From page 10			*		<del> </del>	
	patient care. Emplo of the ICU staff and traumatized by the	revent the interruption tyee #4 acknowledge I nurses were emotion armed hostage drill.	ed several enally	E			:	
	conducted with the (Employee #5) Employee #5) Employee informed by the an armed terrorist doing the ICU unit prior Employee #5 confirm were informed of the the drills implements on 05/24/10 between was conducting multimembers prior to vis Employee #5 reports staff member that an ICU unit wanted to sadministration. Employee when the talk with the speak with her and comeone from admit (assault or threat by	Director of the ICU upologee #5 reported she hospital administration was going to be controlled to the drills implemented none of the ICU e armed terrorist drill ation. Employee #5 ren 9:30 AM and 10:00 siting hours on the ICU ed she was informed a hours on the ICU ed she was informed to speak with someone sloyee #5 reported Enthe subject who refundemented to speak inistration. A code gran unarmed aggres # 12 who observed to the ICU ed to the subject who refundemented to speak with someone who was inistration. A code gran unarmed aggres # 12 who observed to the subject who served to the ICU ed to	nit. ne was ration that conducted entation. I staff prior to eported D AM she with staff CU unit. I by a sect on the from mployee sed to with ey sor) was					
	Employee #5 reporte subjects location with	ed she responded to th Employee #6 and d asked the subject to Employee #5 reporte andished a gun and di Employee #7 and Em break room at the end security guards sittick k room who were dir	made o come od at that irected ployee d of the ng at a ected by			28		

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS2969HOS 06/08/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3001 ST ROSE PARKWAY SAINT ROSE DOMINICAN HOSPITAL - SIENA ( HENDERSON, NY 89052 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ΙĎ PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY S 298 Continued From page 11 S 298 feared for her life and could see that Employee #6 was visibly upset and crying. Employee #5 reported two other staff nurses, Employee # 9 and Employee #10 who had been providing patient care and were out in the hallway were directed to come inside the break room by the gunman and detained. Two physicians were also brought into the break room and detained. Employee #5 reported approximately 5 minutes lapsed until the gunman informed everyone detained in the break room that he was an off duty Metro Police Officer and the incident was a drill. All the employees were detained for an additional 10 minutes inside the break room until the drill was terminated. Employee #5 reported the hospital administration should have notified her in advance of any armed hostage emergency drill and the drill should have been announced overhead as a drill. Employee #5 acknowledged the ICU unit had a full census of 26 patients at the time of the drill and the charge nurse and at least two staff nurses and two physicians were prevented from providing patient care and supervision during the duration of the drill. On 06/08/10 at 12:10 PM an interview was conducted with Employee #7. Employee #7 reported he was providing airway suctioning to a ventilator patient in room 212. Employee #7 reported he heard a code grey called and stepped out into the hallway and saw a male subject who pointed a gun at him. The male subject demanded he get down the hallway and into a break room. Employee #7 reported he feared for his life and though he was going to die. Employee #7 reluctantly complied with the gunman's demands and entered the break room where he saw the charge nurse crying. Employee

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Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS2969HOS 06/08/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3001 ST ROSE PARKWAY SAINT ROSE DOMINICAN HOSPITAL - SIENA ( HENDERSON, NV 89052 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S 298 Continued From page 12 S 298 #7 reported he was detained inside the break room for approximately 5 minutes before the gunman identified himself as an off duty Metro Police Officer and announced the incident was a drill. Employee #7 reported he was detained in the break room for another 10 minutes until the drill was terminated. Employee #7 reported he felt patient care on the ICU unit had been compromised because he was unable to finish suctioning the airway of a patient on a ventilator and could not obtain ABGs (arterial blood gasses) to check the oxygenation level of patient 's blood due to being detained by the drill. Employee #7 reported two nurses and two physicians detained with him in the break room were also prevented from providing patient care during the duration of the drill. Employee #7 reported at no time did the facility announce overhead that the code grey incident was a drill. On 06/08/10 at 1:00 PM an interview was conducted with Employee #9. Employee #9 reported she had been assisting Employee #10 with the patients in room 216 and 217. One of the patients was experiencing periods of bradycardia (low heart rate) and hypotension (low blood pressure). Employee #9 reported she heard a code grey called at room 211 and saw a male subject who looked angry. A short time later she saw the same male subject standing by the break room door and heard a code silver called. Employee #9 reported she and Employee #10 were then detained inside the break room by an armed subject who informed them they were hostages. The subject told her to sit down because she was going to be detained for a while. Employee #9 reported she felt she was involved in a real armed hostage situation and feared for her life. She saw other employees

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FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING\_ NVS2969HOS 06/08/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3001 ST ROSE PARKWAY SAINT ROSE DOMINICAN HOSPITAL - SIENA C HENDERSON, NV 89052 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC (DENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 298 Continued From page 13 S 298 inside the break room were crying and visibly upset. Employee #9 reported two to three minutes elapsed before the subject identified himself as an off duty Metro Police Officer and announced the incident was a drill. Employee #9 reported all the employees inside the break room were detained for an additional ten minutes prior to the termination of the drill. Employee #9 reported she felt patient care had been compromised on the ICU unit because she and Employee #10 were prevented from providing patient care and supervision to a patient experiencing episodes of hypotension and bradycardia and were prevented from providing care to their assigned patients during the duration of the drill. Employee # 9 reported no nurses were assigned to monitor her patients during the time she had been detained in the drill. Employee #9 reported Physician #1 and Physician #2 who had been detained in the break room for ten minutes during the drill complained that they were kept from conducting rounds on sick patients they needed to see. Employee #9 reported none of the ICU staff was notified of the armed hostage drill prior to implementation of the drill and when the code grey and code silver were announced facility staff thought there was a real armed hostage situation occurring on the ICU unit. On 06/08/10 at 1:30 PM an interview was conducted with Employee #11. Employee #11 reported she was walking to the ICU break room with a breakfast tray when she saw a male subject ten to fifteen feet away from her pointing a gun at her. Employee #11 placed the tray down and dialed the hospital operator and called a

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code silver. (assault, threat or hostage situation with an armed aggressor) Employee #11 reported she feared for her life and ran down the hall and

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS2969HOS 06/08/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3001 ST ROSE PARKWAY SAINT ROSE DOMINICAN HOSPITAL - SIENA C **HENDERSON, NV 89052** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY S 298 Continued From page 14 S 298 closed the double doors to the ICU unit. Employee #11 reported she was then told by Employee #1 that the incident was a drill. Employee #11 reported the facility failed to announce the armed hostage incident as a drill and she and the other employees on the ICU unit thought there was a real armed hostage situation. occurring on the ICU unit. Employee #11 reported patient care had been compromised on the ICU unit because the ICU unit had a full census of 26 patients at the time of the drill and the ICU Director, Charge Nurse, two staff nurses and two physicians that had been detained in the break room for approximately ten to fifteen minutes during the drill and were prevented from performing patient care duties. Employee #11 reported many of the nurses on the ICU unit were emotionally traumatized by the armed hostage Severity: 3 Scope: 2 Complaint # 25533

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